MEDICATION AUTHORIZATION FOR STUDENTS WITH ASTHMA

SELF CARRY-SELF ADMINISTER WITHOUT SUPERVISION

WOODRIDGE SCHOOL DISTRICT 68

Student Name: ____

School: ______________________ **Grade:** __________________ **Birth Date:** ____________

Phone Number: ______________________ **Emergency Number:** ______________________

I authorize Woodridge School District 68 and its employees and agents, to allow my child or ward to possess and use his/her asthma medication: **(1)** while in school, **(2)** while at a school-sponsored activity, **(3)** while under the supervision or school personnel, or **(4)** before or after normal school activities, such as while in before-school or after-school care on school-operated property. My child's physician has indicated that my child is capable of self-administration of his/her medication. I will notify the school of changes in the medication or changes in my child's condition. I understand that this permission for self-administration of medication is only effective for the current school year and will need to be renewed each subsequent school year.

Illinois law requires the Woodridge School District 68 to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-carry/self-administration of medication.

Parent/Guardian Signature: ____________________________________ **Date:** ____________

MEDICATION: ______________________________ **DOSAGE:** ______________________

TIME/CIRCUMSTANCES WHEN MEDICATION SHOULD BE ADMINISTERED: ____________________

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SIDE EFFECTS OF MEDICATION: ____

PHARMACY NAME: ____

DATE OF PRESCRIPTION: ____________________ **EXPIRATION DATE:** ____________________

NURSE INITIALS: ____

Parent/Guardian Signature: ____________________________________ **Date:** ____________